

IRO America Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone: 512-266-5815
Fax: 512-692-2924

DATE OF REVIEW:
MAY 18, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
10 Sessions of Physical Therapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
MD Board Certified in Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office note, Dr., 10/04/06, 10/18/06, 11/01/06, 11/29/06, 12/20/06, 01/10/07, 01/31/07,
02/14/07, 03/09/07 and 04/26/07
Lumbar spine MRI, 02/08/07
Denial noted, 03/16/07 and 04/10/07
Lumbar epidural steroid injection/facet block injections, 04/30/07 and 05/14/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a male who was diagnosed with lumbar strain following a twisting injury at work. The claimant began treating with Dr. for low back pain. Exam findings revealed tenderness to palpation to both sides of the lumbar spine, tenderness that extended over the pelvis and sacrum each side. Positive sciatic notch tenderness was noted. Flexion was to 45 degrees, extension to 10 degrees, right lateral bending was to 18 degrees, left lateral bending was to 15 degrees. All range of motion was performed with pain. Motor

was 4/5 right knee and 5/5 on the left. Reflexes were intact bilaterally. Positive straight leg raise was noted and the opposite leg was normal. The claimant had a normal femoral stretch. Normal knee and ankle range of motion was noted. X-rays were negative for a fracture. Diagnosis was lumbar radiculitis, lumbar enthesopathy and lumbar sprain. Anti-inflammatory medications, Vicodin and activity modification were recommended. The claimant improved and returned to regular duty on 11/01/06. The claimant was seen by Dr. on 11/29/06, and on 12/20/06 Dr. instructed the claimant on McKenzie exercises. The claimant continued to have a positive straight leg raise and decreased sensation over the lateral foot although improved. The 02/08/07 lumbar MRI showed diffuse L5-S1 disc bulge with osteophytes contacting the sac and the SI nerve roots. There was no stenosis or neural compression. Minor L4-5 disc bulge without significant effect was noted. There was a disc herniation at T11-12 and T12/L1 and there does not appear to be mass effect on the conus. The T11-12 disc herniation is not well seen.

The claimant saw Dr. on 02/14/07. Flexion was to 40 degrees, extension was to 10 degrees, right lateral bending was to 18 degrees and left lateral bending was to 18 degrees, all with pain. Strength was 5/5. Dr. recommended physical therapy three times a week for seven weeks for modalities, traction and therapy. On 03/09/07, Dr. noted the claimant had completed 9 physical therapy sessions. The claimant still had a positive straight leg raise, flexion was to 41 degrees, extension was to 10 degrees, right lateral bend was to 18 degrees, and left was to 18 degrees, all with pain. The physical therapy request was denied on 03/16/07 and 04/10/07 due to no documented objective improvement. The claimant underwent two lumbar epidural steroid injections and facet blocks on 04/30/07 and on 05/14/07.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The request was for an additional ten sessions of therapy. The claimant has had nine visits but has continued complaints of back pain. The claimant has undergone therapy but is having continued symptoms. The recommendation is for additional therapy. The claimant has only had nine visits to date. I would approve the additional ten visits of physical therapy. After the additional ten sessions of therapy. There is no documentation of progressive neurologic deficits, but the patient has continued back pain. It would be appropriate to proceed with a short course of additional therapy with the goal being advancement to a home exercise program.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)